CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BIIII	DING	00	COMPLETED		
	155409		A. BUILDING B. WING			07/21/2011		
		1	D. WING		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	8			KEYSTONE AVENUE			
WATERS	OF INDIANAPOLIS	S, THE			APOLIS, IN46227			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0000								
	This visit was fo	or a Recertification and	F00	000	Preparation and/or execution			
	State Licensure S	Survey.			of this plan of correction in			
					general, or this corrective action in particular, does no	~ •		
	Survey dates: Ju	ıly 18, 19, 20 & 21, 2011			constitute an admission or			
	-				agreement by this facility o			
	Facility number:	000537			facts alleged or conclusion			
	Provider number				set forth in this statement of			
	AIM number: 10				deficiencies. The plan of			
	Allyl Hullioct. To	00207270			correction and specific			
	a .				corrective actions are prep			
	Survey team:				and/or executed in complia			
	Marcy Smith, Ri	N TC			with state and federal laws.			
	Leia Alley, RN							
	Barb Hughes, Ri	N						
	Karina Gates, M	edical Surveyor						
		•						
	Census bed type:	:						
	SNF/NF: 49							
	Total: 49							
	10ta1. 47							
	Canqua marram t	no:						
	Census payor typ	μ c .						
	Medicare: 6							
	Medicaid: 39							
	Other: 4							
	Total: 49							
	Sample: 13							
	These deficienci	es also reflect State						
	Findings cited in	accordance with 410						
	IAC 16.2.							
	110 10.2.							
	Quality ravious	completed on July 27,						
	Quality review C	ompicica on July 27,						
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NX3P11

Facility ID:

000537

If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155409	B. WING		07/21/2	011
NAME OF I	DROWIDED OF CUIDNITE			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		3895	S KEYSTONE AVENUE		
WATERS	OF INDIANAPOLIS	S, THE	INDIA	NAPOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU		LSC IDENTIFYING INFORMATION)	IAG	Delice.		DATE
F0309 SS=D	must provide the r to attain or mainta physical, mental, a in accordance with assessment and p Based on record facility failed to	st receive and the facility necessary care and services in the highest practicable and psychosocial well-being, in the comprehensive plan of care. review and interview, the ensure the location and	F0309	F309– It is the intent of the for nursing to assess and ide	entify	08/20/2011
	intensity of resid prior to administ medication and followup assessmeffectiveness of of 12 residents as medications in a #13, #44 and #8) Findings include 1. The record of reviewed on 7/20 Diagnoses for Rewere not limited external hip fractions. Recapitulated ph 2011, indicated to Tylenol 650 mg.	ents' pain was assessed ering an as needed pain ailed to conduct a nent to determine the the pain medication for 3 ssessed for receiving pain sample of 13. (Residents		the location and intensity of resident's pain prior to administering an as needed medication and to conduct a follow-up assessment to determine the effectiveness pain medication. 1. ACTION TAKEN: A. In regards to Resident #13, the resident of discharged from the facility of 7-22-2011. B. In regards to Resident #44, a new pain assessment was completed determine effectiveness of the current pain regimen. C. In regards to Resident #8, a new pain assessment was completed determine the effectiveness the current pain regimen. 2. OTHERS IDENTIFIED: A. 11 pain audit of all residents currently receiving pain medication to ensure their curpain regimen is effective. No other residents were identified SYSTEMS IN PLACE: A. All nursing staff in-serviced on 7-28-11 for appropriate	pain of the IS was on to ne he ew eted as of 100% current of 100%	

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10/03/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155409 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3895 S KEYSTONE AVENUE WATERS OF INDIANAPOLIS. THE INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE date 6/4/11) and Oxycodone-Apap 5-325 assessment of pain; determining location and severity of pain; and mg., 1 tablet every 4 hours as needed for appropriate documentation of pain (original order date 6/2/11). pain. In-serviced on follow-up of effectivenessof pain medication and appropriate Review of the Medication Administration documentation. Another Record (MAR) for June, 2011, for in-service will be provided on Resident #13 indicated she received the 8-12-11. **4. HOW** Tylenol on 6/5 at 12:00 (a.m. or p.m. not MONITORED: A. The indicated), 6/9 at 10:00 a.m., and 6/17 at D.O.N./Designee will complete a daily QA Audit X 30 days; then 2:00 p.m. and 8:00 p.m. weekly X 60 days; then monthly for 90 days; to ensure the pain Review of the same MAR for June, 2011 assessments and appropriate indicated the resident received Oxycodone follow-up are completed and documented for any resident on 6/6 at 3:00 p.m., 6/11 at 8:00 a.m., receiving pain medication. B. The 4:00 p.m. and 8:00 p.m. CEO/Designee will review all QA audit as completed in daily QA There was no documentation found on the stand-up meeting. C. The CEO/Designee will review MAR or in the nurses' notes to indicate monthly in QA meeting; and the location of the resident's pain or how quarterly in QA meeting with the severe it was. Medical Director. **5. This plan** of correction constitutes our credible allegation of Further information was requested from compliance with all regulatory the Director of Nursing (DoN) on 7/20/11 requirements. Our date of at 4:30 p.m., regarding nursing compliance is: August 20, assessment of the location and severity of 2011. Resident #13's pain prior to administering her pain medication. On 7/21/11 at 9:35 a.m., the DoN indicated "I have no response for that." A care plan for the resident indicated a problem of "Resident is at risk for uncontrolled discomfort due to hip

fracture," dated 3/24/11. Interventions

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155409	B. WING 07/21/2011				
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			KEYSTONE AVENUE		
WATERS	OF INDIANAPOLI	S, THE			APOLIS, IN46227		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	included but not	limited to, "4. Give as					
	need pain medic	ations as ordered6.					
	Review and adju	st pain medications					
	1	nurse practitioner] as					
	needed"						
	inceded						
	2 The record of	Resident #44 was					
	reviewed on 7/1	9/11 at 8:45 a.m.					
	"	esident #44 included, but					
	were not limited	to, acute kidney failure,					
	morbid obesity,	schizoaffective disorder					
	and chronic airw	yay obstruction with					
	tracheostomy.						
	Recapitulated ni	nysician's orders for July,					
		he resident could receive					
		1 tablet every 6 hours as					
		riginal order date					
	5/11/11).						
	The MAR for Ju	ine, 2011, indicated					
	Resident #44 red	ceived Tylenol on 6/1 at					
	6:00 p.m., 6/3 at	3:00 a.m., 6/11 at 4:00					
		:00 p.m., 6/20 at 5:00					
	a.m. and 6/25 at	-					
	a.iii. aiia 0/23 at	р.ш.					
	There was no do	cumentation found on the					
		urses' notes to indicate					
		ne resident's pain or how					
	severe it was.						
	Further informat	tion was requested from					
		Nursing (DoN) on 7/20/11					
		<u> </u>					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	ETED	
		155409	B. WING			07/21/2	011	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	R	3	3895 S	KEYSTONE AVENUE			
	S OF INDIANAPOLI				APOLIS, IN46227			
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	I '	NCY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)	1	ΓAG	BEI ICIEI(C1)		DATE	
	at 4:30 p.m., reg							
		ne location and severity of						
	1	pain prior to administering						
	1 -	tion. On 7/21/11 at 9:35						
	a.m., the DoN in	ndicated "I have no						
	response for tha	t."						
	A care plan for l	Resident #44 indicated a						
	1 -	sident is at risk for						
	1 ^	ontrolled discomfort"						
	1 ^	cluded but were not						
		Give as needed pain						
		ordered6. Review and						
	adjust medication							
	1 "	record for Resident #8 was						
	1							
	reviewed on 7/2	0/11 at 10:30 a.m.						
	Resident #8's di	agnoses included, but						
		I to: Parkinson's Disease,						
	Depression, Seiz	zures, Constipation, and						
	Dementia.	•						
	The July. 2011 r	ohysician's recapitulation						
	1	Acetaminophen 325 mg to						
		4 hours PRN (as needed)						
	1 -	original order date of						
	1/25/11.	original order date of						
	1/23/11.							
	The June, 2011	MAR (Medication						
	•	Record) and July, 2011						
		ewed on 7/20/11 at 10:45						
	1	eated Resident #8 was						
	-	ophen 325 mg on June 9,						
	1 -	n., June 23, 2011 at 6:00						
	2011 at 8.00 a.m	1., June 23, 2011 at 0.00						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155409		(X2) MULTIPLE CONSTRUCTION A DULL DING 00				(X3) DATE SURVEY COMPLETED		
				DING			07/21/2			
			B. WINC		DDRESS, CITY, STATE	ZID CODE	·· -			
NAME OF P	ROVIDER OR SUPPLIER	L.			KEYSTONE AVEN					
WATERS	OF INDIANAPOLIS	S, THE			APOLIS, IN46227					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOWIDEDIS DI AL	N OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED		·F	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICII	ENCY)	_	DATE		
	a.m., June 28, 20	11 at 5:00 p.m., and July								
	8, 2011 at 3:00 a	.m.								
	There was no do or in the nurses' resident was asses intensity/nature of administering the the effectiveness the medication was Resident #8's car reviewed on 7/20 indicated nursing medication as or with effectiveness. During an interval Nursing on 7/19/indicated when generated when generate	cumentation on the MAR notes to indicate the essed for the location or of the pain prior to e pain medication or for of the medication after was given. The plan for pain was 0/11 at 11:15 a.m. It g is to give PRN dered and to follow up								
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	 NX3P11	Facility II	D: 000537	If continuation sh	neet Par	ge 6 of 11		

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			COMPLETED		
	155409		B. WING			07/21/2	.011	
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE			P. WE	STREET A 3895 S	ADDRESS, CITY, STATE, ZIP CODE KEYSTONE AVENUE IAPOLIS, IN46227	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
F0371 SS=F	considered satisfa local authorities; a (2) Store, prepare, under sanitary cor Based on observatinterview, the fact food was covered freezer, opened of were properly lab and hot dog buns not conducive to had the potential residents at the fact foods served out Findings include On 7/18/11 at 9:4 kitchen was conducive to had the potential residents at the fact foods served out Findings include On 7/18/11 at 9:4 kitchen was conducive to had the potential residents at the fact foods served out Findings include On 7/18/11 at 9:4 kitchen was conducive to had served out During observation of the pack buns were found 7/12/11. One pack was found to have substance on one Dietary Manager	distribute and serve food ditions ation, record review and cility failed to ensure d while stored in the ontainers of sour cream beled with open dates, were stored in a manner mold production. This to affect 49 of 49 acility who consume of the kitchen.	F0	371	F371 – FOOD PROCURE, STORE/PREPARE/SERVES ARY. It is the intent of the fato ensure food is covered w stored in the freezer; open containers are dated with opdates; and hot dog buns are stored in a manner to preve mold production. 1. ACTIO TAKEN: A. All identified fo items were immediately rem from the storage areas and discarded. DM audited all storage areas for proper storage areas for proper storand dating of items when opened. 2. OTHERS IDENTIFIED: A. All resider would have the potential to affected. 3. MEASURES IN PLACE: A. All Dietary Staffin-serviced on 8-11-11 regathe proper guidelines for footstorage in the freezer/refrigemarking the date an item is opened; and adherence to protation and/or disposal of outdated bread. 4. MONITORING IN PLACE: DM/Designee will do randor audits daily in regards to prostorage in the freezer/refrigering in th	acility hile pen e nt DNS od noved prage hts be ff were arding od erator; proper A. m opper	08/20/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NX3P11

Facility ID:

000537

If continuation sheet

Page 7 of 11

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	ll la l		A. BUI	LDING	00			
		155409	B. WIN			07/21/20	J11	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE			
WATER.	OF INDIANABOLI) THE		1	KEYSTONE AVENUE			
	OF INDIANAPOLIS			INDIAN	APOLIS, IN46227			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE	
IAG		LSC IDENTIFFING INFORMATION)	-	IAU	items dated when opened; a	nd	DATE	
	room.				proper rotation of and/or disp			
	D since index is	M. d. Distan			of outdated bread. B. The			
	~	with the Dietary			CEO/Designee will monitor			
	_	/11 at 10:15 a.m., she			weekly for proper storage in freezer/refrigerator; items da			
		nd is used on a first in			when opened; and proper ro			
		and the hot dog buns			of and/or disposal of outdate			
	were overlooked.				bread. C. The CEO/Designe review all audits as They are			
	During observation	on of the freezer, a pan of			completed in the daily QA			
		el sprouts was stored on			stand-up meeting;Monthly in			
	the bottom shelf. The Dietary Manager removed the brussel sprouts from the freezer.				QA meeting; and quarterly in			
					QA meeting with the Medical Director. 5. This plan of			
					correction constitutes our			
	1100201.				credible Allegation of			
	During observation	on of the refrigerator,			compliance with all regulat	-		
	_	f opened sour cream were			Requirements. Our date of compliance is: August 20,			
	found with no op	en or use by date. The			2011.			
	Dietary Manager	removed both containers						
		om the refrigerator.						
		-						
	The Date Markin	g Policy provided by the						
	Dietary Manager	on 7/21/11 at 3:45 p.m.,						
	was reviewed on	7/21/11 at 4:00 p.m.						
	The policy indica	ated expiration dates on						
	commercially pre	epared, dry storage food						
	items will be foll	owed. It also indicated						
	the individual ref	frigerated food items are						
		te the item was received						
	into the facility a	nd placed in/on the						
	proper storage lo	cation and once opened,						
		dous food will be						
	re-dated with a u							
	3.1-21(i)(2)							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
155409		A. BUILDING	00	07/21/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	********
NAME OF I	PROVIDER OR SUPPLIER		ı	KEYSTONE AVENUE	
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F9999	3.1-21(i)(3) 3.1-21(i)(3) 3.1-14 PERSON (u) In addition to hours in subsection regular contact with minimum of six (dementia-specific months of initial 30 days for personal Alzheimer's and unit, and three (3) thereafter to meet preferences, or be impaired resident understanding of care for residents. This state rule was by:	NEL the required in-service on (1), staff who have rith residents shall have a (6) hours of c training within six (6) employment or, within much assigned to the d dementia special care hours annually t the needs, or oth, of cognitively as and to gain the current standards of with dementia. as not met as evidenced review and interview, the	F9999	STATE TAG #9999: PERSONNEL It is the intent this facility for all employees receive 3 hours of dementia training annually. 1. ACTION TAKEN: A. Employees #3 #6; #9; #10; #11; #13; and 14: an additional hour of dementia specific training will provided to complete the and three hour requirement. 2. OTHERS IDENTIFIED: A. 1 audit of all employee records hours of dementia specific training annually. An in-serv will be provided on 8-16-11 from any employees identified. 3. MEASURES TAKEN: A. All mandatory in-services/training and education will be scheduled on an annual basis; including quarterly dementia specific training (a minimum of one hour in leng Attendance will be made mandatory and will be monited. HOW MONITORED: A. Human Resources/Designee.	of to NS ; # 4; d # Il be hual 00% s for 3 rice for ng lled g a ath). ored.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155409 07/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3895 S KEYSTONE AVENUE WATERS OF INDIANAPOLIS. THE INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE employees hired before June, 2010, audit/monitor all in-service attendance and will audit received 3 hours of dementia training employees files quarterly to annually. (RN's # 3, #6, LPN's # 4, ensure completion of mandated dementia specific in-services. #10, CNA #9, Cook #11, Activities . B. CEO/Designee will review all Director #13, Maintenance #14) audits as completed at QA stand-up meeting; monthly in QA Findings include: meeting; and quarterly in QA Employee files were reviewed on 7/21/11 meeting with the Medical Director. at 9:00 a.m. The following employees 5. This plan of correction constitutes our credible files did not include the required dementia allegation of compliance with training. all regulatory requirements. Our date of compliance is: RN #3 was hired on 1/12/10. There was August 20, 2011. documentation of 2 hours of dementia training within the last year. LPN # 4 was hired on 3/16/10. There was documentation of 2 hours of dementia training within the last year. RN #6 was hired on 1/26/10. There was documentation of 2 hours of dementia training within the last year. CNA #9 was hired on 5/13/2004. There was documentation of 2 hours of dementia training within the last year. LPN #10 was hired on 9/8/2009. There was documentation of 2 hours of dementia training within the last year. Cook #11 was hired on 3/23/1995. There was documentation of 2 hours of dementia training within the last year. Employee #13 (Activity Director) was

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NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE				STREET A 3895 S	LDDRESS, CITY, STATE, ZIP CODE KEYSTONE AVENUE APOLIS, IN46227		
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	hired on 4/26/20 documentation of	10. There was of 2 hours of dementia					
	training within the	he last year. Maintenance) was hired					
	on 1/4/2010. Th	ere was documentation of ntia training within the					
	last year. Employee In-Se	rvice records were					
	records indicated						
	4/9/11.	held on 9/10/10 and					
	Administrator or	iew with the Facility n 7/21/11 at 3:30 p.m., she					
	in-services withi	n the last year for					
	conducted was a	nt each in-service pproximately 1 hour in					
	length. 3.1-14(u)						